

## **Legislative Report**



### **Report to the Legislature**

# **Alternative Approaches for Using Client Acuity To Establish Nursing Home Direct Care Rates**

Chapter 8 Laws of 2001, E1, Section 18 (5)

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# **Legislative Report - Alternative Approaches for Using Client Acuity To Establish Nursing Home Direct Care Rates**

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### **BACKGROUND**

Chapter 8 Laws of 2001 E1, Section 18 (5) states:

By December 1, 2001, the department of social and health services shall report to the joint legislative task force on nursing homes on alternative approaches for using client acuity to establish DC rates. The alternatives shall link acuity, as measured by case mix, to the number of hours of service estimated to be provided for each client, and shall multiply those estimated service hours by standard wage and benefit rates which account for differences in direct care labor costs in various areas of the state. The alternatives reviewed shall provide cost controls and incentives at least equal to the current rate-setting system, and shall not contain automatic cost increases, automatic indexing, hold harmless provisions, or mandatory future rebasing of costs.

### **INTRODUCTION**

Before addressing alternative approaches for using client acuity to establish direct care (DC) rates, a review of the current nursing facility (NF) payment system may be helpful. Currently, all NFs submit yearly cost reports to Aging and Adult Services Administration (AASA). Cost reports include revenues and expenses that the NF claims to have incurred for the calendar year. AASA examines the reported costs and adjusts out those costs that are determined to be unallowable to establish the NF's Medicaid payment rate. Nursing facility Medicaid payment rates are facility-specific and consist of seven rate components: Direct Care (DC), Therapy Care, Support Services, Operations, Property, Financing Allowance, and Variable Return.

The subject of this report is the DC component, which includes nursing services, of the NF rate. Costs categorized as nursing services include wages and benefits of staff such as RNs, LPNs, and CNAs who provide direct care to nursing facility residents. Currently, AASA sets a nursing facility's DC rate component by a case mix system. With case mix, a nursing facility's DC payment rate is based primarily on characteristics of the NF residents that will generate care needs.

The essential elements of a case mix payment system are

- Collection of data on each resident

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- Classification based on care needs
- Identification of resources needed to care for residents of each classification

### **DATA COLLECTION**

Data is collected on the NF resident at various times during the resident's stay in the NF, but at least quarterly. The data collected includes identifying information, diagnoses, treatments, social preferences, and the amount of assistance needed with activities of daily living (ADL).

Aging and Adult Services Administration uses the Minimum Data Set (MDS) Version 2.0 effective April 1, 1996 to collect the required resident data. The MDS is a federally mandated screening, assessment and care planning tool that indicates the strengths, needs, and preferences of a resident. All certified nursing facilities in the United States must use the MDS. All Washington State nursing homes electronically submit their MDSs to AASA, which then transmits the MDS data to the Center for Medicare/Medicaid Services (CMS) (formerly the Health Care Financing Authority, (HCFA)).

### **CLASSIFICATION**

In 1990, HCFA conducted a time study in nursing homes around the nation. The time study has been updated several times since 1990, most recently in 1997. Beginning in 1990, HCFA incorporated into the time study information obtained from more than 9,000 nursing home residents around the United States including Washington. The time study collected data on resident characteristics and the time required to care for a resident with certain characteristics.

The Health Care Financing Authority analyzed the time studies and resident assessment information collected to determine the assessment elements that correlate with the time needed to care for each resident type. The assessment elements identified were:

- Clinical characteristics e.g., diagnoses and conditions;
- Service types or counts e.g., therapies, nursing rehabilitation, extensive services, etc.
- Activities of Daily Living (ADL)

The result of the analysis is known as the Resource Utilization Group Version III (RUG-III) classification system that groups residents into one of 44 groups.

Aging and Adult Services Administration processes the MDS data e.g., diagnoses, treatments, and ADL's and the degree of assistance the resident requires to perform the

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ADLs through a RUG-III computer software program. The RUG III assigns each resident to one of the 44 groups.

### **RESOURCE IDENTIFICATION**

To each of the 44 groups, AASA assigns a case mix weight. The case mix weight is a “relative weight” because it reflects the resources required to care for an individual in a group relative to the lowest care need NF resident whose case mix weight by statute is set at 1. A higher case mix weight reflects a resident with heavier care needs and a lower case mix weight reflects a resident with lighter care needs.

### **CASE MIX DIRECT CARE RATE**

#### **I. RUG groups and Case Mix Weight**

Every three years when setting the price of care for the 44 RUGs, AASA uses statewide wage and benefit data without any peer group distinctions to set a case mix weight for each RUG group. For example, caring for a person in one of the 44 RUGs groups may take on average “x” minutes of care by an RN, “y” minutes of care by an LPN, and “z” minutes of care by a certified nurse aide. The case mix weight for each of the 44 RUGs groups reflects both the average amount of time required to care for clients in that group and the average wage of the caregivers. Establishment of the case mix weight is an indirect way that Washington’s current case mix payment methodology links acuity with hours of care and wage and benefit levels.

#### **II. NF Costs, CMI, and the Direct Care Rate**

Each nursing facility has its own case mix index (CMI). This is the average case mix weight of the clients served in that nursing facility.

To set a NF’s direct care rate, AASA

- A) Establishes a cost per case mix unit for each facility. The cost per case mix unit is the total allowable DC costs for that facility divided by the facility CMI;
- B) Arrays the cost per case mix unit for facilities in similar geographic areas and establishes a median cost per case mix unit for the geographical area;
- C) Establishes upper and lower payment limits at 90% and 110% of the median cost per case mix unit for the geographical area. Facilities whose cost per case mix unit are higher than 110% of the median have their rate based on 110% of the median, facilities whose cost per case mix unit are lower than 90% of the median receive a rate based on 90% of the median, and facilities whose cost per case mix unit are between 90 and 110 % of the median have their rate based on their cost per case mix unit.

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### **III. Recent changes in the case mix payment methodology**

In the 2001 Legislative session, two changes were made to the statutory case mix payment methodology.

First, the Legislature revised the nursing home payment statute (Chapter 74.46 RCW) to provide for the use of three geographic peer groups when calculating cost per case mix unit medians. This change was in response to testimony that nursing facilities in certain urban counties have higher wage costs and therefore, were disadvantaged by the previous use of only two peer groups (essentially urban and rural). The third peer group that was established in statute in 2001 reflects the experience of “high labor-cost counties”.

Second, in 2001 the Legislature removed the statutory requirement that the cost per case mix unit medians be adjusted over time. Prior law required that, over time, the floor and ceiling used to calculate the allowable cost per case mix unit (previously 90% and 110%) be reduced to 95% and 105% of median. Prior law envisioned that by July 2004 the floor and ceiling would be removed entirely -- all facility rates would be based on the median cost per case mix unit.

These revisions to the law allow more nursing facilities to have their actual costs reimbursed. To the extent that their clients' acuity required higher hours and/or payment of higher wages, these costs would be more likely to be reimbursed.

### **LIMITATIONS OF CURRENT CASE MIX SYSTEM**

Most payment systems use limits of some sort to identify and keep from paying unnecessary costs. Use of limits in the DC cost center implies that some nursing facilities will not have some direct care costs recognized. The DC cost component is arguably the component most related to provision of quality care and it is therefore important that limitations in the payment system be appropriately targeted to accomplish policy goals.

The current case mix system does not take into account the cause of a NF's costs being above the ceiling of its peer group and therefore subject to payment limitations. A NF's increased costs may be the result of paying higher wages to DC staff or utilizing more care hours, important policy goals. However, states have a legitimate need to put limitations on how much they will pay, even in the cost component that is closely tied to quality patient care. States' policy dilemma is to develop ways to identify and reimburse only necessary and efficient costs.

### **ALTERNATIVES WITHIN THE CURRENT CASE MIX SYSTEM**

As mentioned, SHB 2242 requires the department to identify alternatives for tying acuity (using case mix principles) to hours of service and a standard wage. The law requires

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that these alternatives be essentially “budget neutral”. The following are some alternative approaches using the current case mix system to increase the DC rate for a NF with costs above the ceiling that result from higher wages or more care hours. These alternative methods use CMIs that may better reflect the acuity levels identified by the MDSs, higher staffing levels, and/or hourly wage costs in setting a DC rate.

### **ALTERNATIVE #1 – Separate RUG Group Weights by Peer Groups**

This alternative proposes separating RUG group weights by peer groups based on:

- Geographic location; or
- NF type

Instead of using the current system of having 1 set of 44 RUGs, this alternative would include three sets of RUGs based on either geographic location or type. This would result in a NF CMI reflecting wage differences based on either the nursing facility location or the type of facility.

For instance, if geographic locations are used, the RUGs could be divided into peer groups for King County, all other Metropolitan Statistical Areas (MSA), and Non-Metropolitan Statistical Areas (Non-MSA). If nursing facility type were used, RUGs could be divided into peer groups for governmental, non-profit and for-profit facilities.

#### **POSITIVES**

- Wage differences between peer groups would be reflected in the NF’s CMI.

#### **NEGATIVES**

- No better direct correlation between case mix indexes and wages than provided by the current payment methodology.
- Administrative complexity leading to higher administrative costs for AASA.
- Would shift the burden of unrecognized DC costs between peer groups.

### **ALTERNATIVE #2 – Incentives for NFs with Higher Cost Per Bed Based on Acuity**

Alternative #2 provides a monetary incentive to NFs that have higher costs per bed based on acuity, and monetary disincentives for NFs with lower cost per bed based on acuity.

I. Using this alternative approach to determine the DC rate, AASA could:

- A. Sum by NF, all rebase year allowed purchased and allocated DC costs and hours by peer groups, based on the geographic locations of King, MSA and non-MSA.
- B. Divide the NF’s total DC hours by the product of its licensed beds times occupancy percentage to determine a NF’s “hours per bed”;
- C. Divide total DC costs by total DC hours to determine a NF’s hourly wage;

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- D. Divide the “hours per bed” by the rebase year facility average case mix index and multiply the result by the NF’s hourly wage to create a link of the “hours per bed” to acuity. The product is “acuity cost per bed”;
- E. Array by peer group each NF’s “acuity cost per bed” to derive a median;
- F. Compare a NF’s “acuity cost per bed” to its peer group “acuity cost per bed” median;

### **II. If a NF’s “acuity cost per bed” is:**

- A. Less than the 90% floor of its peer group, AASA would assign the NF an **“acuity cost per bed”** equal to 90% of its peer group median;
- B. Greater than the 110% ceiling of its peer group, AASA would assign the NF **“acuity cost per bed”** equal to 110% of its peer group median; or
- C. Between 90% floor and 110% ceiling of its peer group, AASA would use the NF’s actual **“acuity cost per bed”**.

III. AASA could use the acuity cost per bed to add an incentive to the rate of those NFs with an “acuity cost per bed” set at 110%. The assumption is that these facilities have a higher cost per bed because they pay higher wages and/or have more hours of care.

For NFs with an “acuity cost per bed” set at 90%, AASA could reduce their rates to provide for the cost of the incentive.

### **POSITIVES**

- Hours are factored in to account for the higher costs of caring for higher acuity residents.
- Revenue neutral.

### **NEGATIVES**

- No direct correlation between higher wages or increased hours and quality of care.
- NF that gives lower quality care at a higher cost would benefit.
- To maintain budget neutrality, a NF that gives good care at a lower cost would be paid less to provide for the incentives for high cost facilities.
- Administrative complexity leading to higher administrative costs for AASA.

### **ALTERNATIVE #3 Actual Cost per Bed Compared to Time Study Cost Per Bed**

This alternative would provide monetary incentive to NFs that have more care costs per bed than CMS Time Study estimated costs per bed as determined by comparison with the RUG associated with its facility average case mix index.

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I. Every three years when setting the price of care for the 44 RUGs, AASA uses current statewide nursing facility cost report wage and benefit data and the CMS Time Study hours to set a case mix weight for each RUG group.

II. To determine the DC rate, using this alternative approach, AASA could:

- A. Sum by NF all rebase year allowable in-house purchased and allocated RN, LPN and nursing aide costs and hours by peer groups based on the geographic locations of King County, MSA and non-MSA.
- B. Compare the actual RN, LPN, and nursing aide hours with its facility average case mix index Time Study hours.
- C. Calculate an “estimated Time Study hours per bed” by multiplying the Time Study hours for the facility’s RUG group by the report period days and dividing by the product of licensed beds times occupancy.
- D. Calculate the actual hours per bed by dividing the actual RN, LPN and nursing aide hours by the licensed beds times occupancy.
- E. Multiply both the Time Study hours per bed and the actual hours per bed by the NF hourly wage to calculate the “Time Study cost per bed” and the “actual cost per bed”.
- F. Compare the “Time Study cost per bed” and the “actual cost per bed”. If the “actual cost per bed” is above the “Time Study cost per bed”, the facility may qualify for a higher DC rate.
- G. Compare the facility specific “actual cost per bed” to the median cost per bed for the corresponding peer group. If the costs are 110% or more above the peer group median, the nursing facility would qualify for a DC rate incentive. Facilities that are below their 90% peer group median would be given a DC rate disincentive. This disincentive would fund this alternative.

### **POSITIVES**

- For NFs with higher care costs because of more hours of care, actual RN, LPN and nursing aide hours would be used to determine an incentive.
- Revenue neutral.

### **NEGATIVES**

- No direct correlation between increased hours and quality of care.
- NFs that provide quality care through DC staff other than RN, LPN and aide may not be rewarded.

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- NF that gives more hours of care but has mediocre care would benefit.
- To maintain budget neutrality, a NF that gives good care with fewer hours would be paid less to provide for the higher rates for high hour facilities.
- Administrative complexity leading to higher administrative costs for AASA.

### **ALTERNATIVE #4 Wages, Hours of Care, & Quality Care**

While legislation required AASA to review the direct care case mix component, this fourth alternative provides a different approach.

Using the current case mix system, in the alternatives described above, AASA would use the data from all NFs to make adjustments to the case mix system to increase the rates of NFs that have higher DC costs. The difficulty in all three alternatives is the lack of a quantifiable way to ensure that only facilities that are providing quality care benefit from incentives based on higher costs or higher hours.

The following alternative provides incentive rate add-ons to the DC rate component for facilities that meet certain quality of care criteria.

The criteria AASA could use to evaluate a NF's request for a DC rate increase would include but not be limited to the following:

- Staff turnover
- Employee satisfaction
- Employee wages and benefits
- Standards in quality of care
- Number of substantiated complaints per facility
- Demonstrable quality of life within the facility

The money for this alternative could be funded through the reduction and/or elimination of the Variable Return rate component.

Under the current reimbursement system, nursing facilities receive an efficiency incentive through the Variable Return rate. Facilities receive an additional 1 – 4 percent of the sum of DC, TH, SS and OP component rates depending on whether their costs are high or low in comparison with the rest of the industry. The facilities with the lower costs receive the 4 percent additional funding, while facilities with the higher costs receive 1 percent.

The current Variable Return system provides incentives to lower costs in the DC rate component in order to receive a higher Variable Return rate.

To fund this alternative, Variable Return could be reduced or eliminated. Reducing Variable Return could be accomplished by lowering the percentages to 0-3 and only using TH, SS and OP components in the Variable Return calculation.

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This alternative provides funds to reward NFs with a DC rate equal to its peer group ceiling that demonstrate that residents receive high quality care and have a high quality of life. Also, the NF would need to demonstrate that the resident satisfaction is directly related to increased hours of care, low staff turnover, high staff salaries, and high employee satisfaction.

### **POSITIVES**

- Rewards a NF that proves high quality of care and quality of life to its residents.
- Removes incentives to under spend in DC.
- Rewards a NF that develops strategies to keep staff through employee satisfaction
- Reduces or eliminates Variable Return
- Budget neutral

### **NEGATIVES**

- Requires additional information from NFs and more staff time to verify quality of care and quality of life.
- Requires additional information from NFs and more AASA staff time to document staff turnover and employee satisfaction.
- Eliminating or reducing the variable return component would be strongly opposed by the nursing home industry.

### **CONCLUSION**

The 2001 Guide to the Nursing Home Industry, prepared by HCIA-Sachs L.L.C., and Arthur Anderson LLP concluded:

Currently no states have reimbursement systems that link acuity as measured by case mix to the numbers of hours of service provided for each client and multiplies those estimated service hours by standard wage and benefit rates which account for difference in DC labor costs in various state areas.

Washington's current payment methodology indirectly recognizes the link between client acuity, hours of service, and wage levels. Changes made to the payment methodology by the Legislature in 2001 strengthen those links. There are alternative methods of calculating payment that would allow higher payments to facilities with higher direct care costs relative to their peers. And, there are alternatives to try to target higher payments to facilities providing good quality of care. However, like all payment methodologies, these alternatives have weaknesses. Policy makers must decide whether the weaknesses of these alternatives are outweighed by their strengths.